



**DOUGLAS INDIAN ASSOCIATION
Tribal Government**

811 West 12th Street, Juneau, Alaska 99801-1529
Phone: (907) 364-2916 Fax: (907) 364-2917



If yes, list the name of household member and Corporation(s) here: (use backside of form if necessary)

MEMBERS OF HOUSEHOLD WHO OWN SHARES IN A NATIVE CORPORATION		
NAME	NATIVE CORPORATION	# SHARES OWNED

- Have you received ATAP or TANF in the last month: Yes No If yes, how much: \$ _____
- Has your ATAP/TANF been reduced due to penalties: Yes No Reason: _____
- Have you been terminated from ATAP/TANF: Yes No Date of termination: ___ / ___ / ___
- Have you been determined ineligible for ATAP/TANF: Yes No Reason: _____
- Have you been denied ATAP/TANF: Yes No Reason: _____
- Are you eligible to reapply for ATAP/TANF: Yes No Date able to reapply: ___ / ___ / ___
- What TANF office did you receive assistance from: Please list: _____

EXPLAIN FULLY, how you have supported yourself during the past three (3) months and what has changed in your situation to cause you to apply for assistance. **Failure to complete this section will render this application incomplete & therefore will not be processed.**

Do you have an Individual Indian Money (IIM) account? Yes No

RECORD OF INCOME AND RESOURCES

Does anyone in your household have income from any source? Yes No
If yes, list the name of household member(s), source of income and amounts below.

*****YOU ARE REQUIRED TO REPORT INCOME RECEIVED FROM THE FOLLOWING*****

SOURCE OF INCOME & RESOURCES	AMOUNT	NAME OF HOUSEHOLD MEMBER
Salary #1: Applicant's Income/Salary	\$	
Salary #2: Spouse's Income/Salary	\$	
Tips or Gratuities	\$	
ATAP -TANF-ASAP (State assistance)	\$	
Child Support and Alimony	\$	
Foster Care Payments	\$	
Adult Public Assistance (APA)	\$	
Social Security (SSA RETIREMENT)	\$	
Supplemental Security Income (SSI)	\$	
Disability Insurance (SSDI or private ins.)	\$	
Alaska State Permanent Fund (PFD)	\$	



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Cashouts of Retirement or Pension Plans	\$	
State Longevity	\$	
Veteran's Benefit	\$	
Unemployment Insurance Benefits	\$	
Worker's Compensation	\$	
Food Stamps	\$	
Medicare/Medicaid	\$	
Native Corporation Dividends	\$	
Checking Account (provide statement showing balance)	\$	
Savings Account (provide statement showing balance)	\$	
Student Loans/Grants/Scholarships	\$	
Bingo or Pull Tab Winnings	\$	
Other Income	\$	
TOTAL MONTHLY INCOME	\$	

MONTHLY SHELTER COSTS

*****PROVIDE ALL EXPENSES FOR THE CURRENT MONTH*****

Rent	\$	Telephone	\$
Space Rent	\$	Water	\$
Mortgage Payment	\$	Sewer	\$
Electricity	\$	Household Oil/Fuel/Wood	\$
Heating	\$	Other	\$

READ BEFORE SIGNING

I/We apply for financial assistance/ services for the listed members of my (our) household who are in need.
I/We have received a copy of and have had explained to us, and understand the provisions of Federal Law governing fraud.

Applicants or recipients who knowingly and willfully provide false or fraudulent information are subject to prosecution under 18 U.S.C. §1001, the Federal Law concerning fraud which carries a fine of not more than \$10,000 or imprisonment of not more than five years or both. Initials of applicant_____

I (We) agree to supply information regarding resources and income and to notify the agency of any changes in my (our) situation. Release of Information: Human Services is authorized to obtain/exchange information necessary to establish eligibility for assistance. I (We) have read, or had explained to me/us, the provision of our protection under the Paperwork Reduction Act and the Privacy Act. Initials of applicant_____

Applicant Signature

Signature of Other Adult Household Member

Printed Name

Printed Name

Date

Date

